Patient Consent Form for Electronic Exchange of Individual Health Information	For Provider Use: MRN_____

PLEASE READ THIS ENTIRE DOCUMENT BEFORE SIGNING THE CONSENT FORM.

Please provide the following information:

PATIENT NAME Last First Middle

PREVIOUS NAME(S) _____ **GENDER:** M__F___

STREET ADDRESS/P. O BOX

CITY _____ **STATE** _____ **ZIP CODE** _____

PHONE NUMBER (OPTIONAL) _____

DATE OF BIRTH (MM)_____(DD)_____(YYYY)_____

CONSENT: I understand that if I give consent below, I am allowing [Name of Provider Organization] to release and/or access ALL of my electronically available individual health information. Electronically available individual health information may include information from my health care providers, including hospitals, physicians, clinics, pharmacies, labs, and other licensed providers, as well as a third party organization (called a Health Information Organization (HIO)) that assists in the exchange of my information.

PURPOSE: I understand that my individual health information that is electronically disclosed to health care providers may be used to provide me with medical treatment, assess/improve the quality of my medical care, and to facilitate public health reporting. Examples of health care providers include, but are not limited to, the following: physicians, nurses, hospitals, clinics, pharmacies, labs, other licensed providers, heath care staff, and HIOs.

TYPES OF INFORMATION INCLUDED IN THIS CONSENT: I understand that this consent permits [Name of Provider Organization] to access and disclose ALL of my electronically available individual health information, including but not limited to, information related to drug/alcohol abuse, HIV/AIDS testing, status or treatment; genetic diseases or genetic tests; family planning/reproductive care; sexually transmitted diseases; mental health, emergency care records, nursing notes, laboratory results, pathology reports, x-ray reports, films, and all other individual health information as allowable under applicable law.

YOUR SIGNATURE: I understand that my consent becomes effective upon signing this form and will remain in effect until I submit a written request to revoke it. I understand that I have the right to withdraw or revoke this consent in writing at any time, except to the extent that the electronic

health information has already been released to another entity. This consent permits access to and disclosure of my individual health information created both before and after the date I sign this form.

My Consent Choices:

☐ ***I GIVE CONSENT FOR [Name of Provider Organization] to release and/or access ALL of my electronic health information through health information organization(s) in connection with providing me any health care services, including emergency care.***

☐ ***I DENY CONSENT FOR [Name of Provider Organization] to release and/or access any of my electronic health information through health information organization(s) EXCEPT in the event of a medical emergency.***

☐ ***I DENY CONSENT FOR [Name of Provider Organization] to release and/or access any of my electronic health information through health information organization(s) even in the event of a medical emergency.***

Signature of patient or authorized representative:
If I sign this form as the Patient's Authorized Representative, I understand that all references in this form to "I", "me" or "my" refer to the Patient.

_____ _____
Date

If signed by someone other than the patient, print name and indicate relationship:

_____ _____ _____
Authorized Representative *Relationship* *Date*

Address of authorized representative signing this form (please print):

_____

Phone number of authorized representative signing this form:

_____

Signature of witness:

Witness required only for telephone consent, physical inability to sign, or signature by mark. Telephone consent is subject to verification of identity.

_____ _____ _____
Witness *Relationship* *Date*